

Patient Information Form

Today's Date: _____

Patient Name (First) _____ (Middle) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Patient's email address: _____

Social Security Number (for Insurance purposes only) _____ Date of Birth _____

Gender (Please Circle) Male Female Marital Status (Please Circle) Single Married Separated Divorced Widowed

Occupation _____ Employer _____

Employer's Address _____ City _____ State _____ Zip _____

In case of an emergency, who should be notified? _____

Relationship to Patient _____ Contact phone number _____

Dental Benefit Plan Information

Primary Dental Plan _____ Phone Number _____

Name of Primary Subscriber _____ Date of Birth _____ ID Number _____

Secondary Dental Plan _____ Phone Number _____

Name of Primary Subscriber _____ Date of Birth _____ ID Number _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is complete in advance of performing any treatment with our practice. We accept the following forms of payment- CASH, CHECK, and all major Credit Cards, including Visa, Mastercard, Discover, and Amex. **Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefits Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fees as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we require 48-hours notice to reschedule an appointment. With less than 48-hour notice, a fee \$222.00 or deposit to reserve the appointment time again, may be required. To serve all patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$222 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ **(initials)**

I have read the above and agree to the financial and scheduling terms. _____ **(initials)**

I hereby acknowledge the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me YES/NO (circle one) _____ **(Initial)**

I hereby acknowledge that a copy of this practice's Notice of Private Practices and Dental Material Fact Sheet has been made available to me. _____ **(Initials)**

Signature _____ **Date** _____